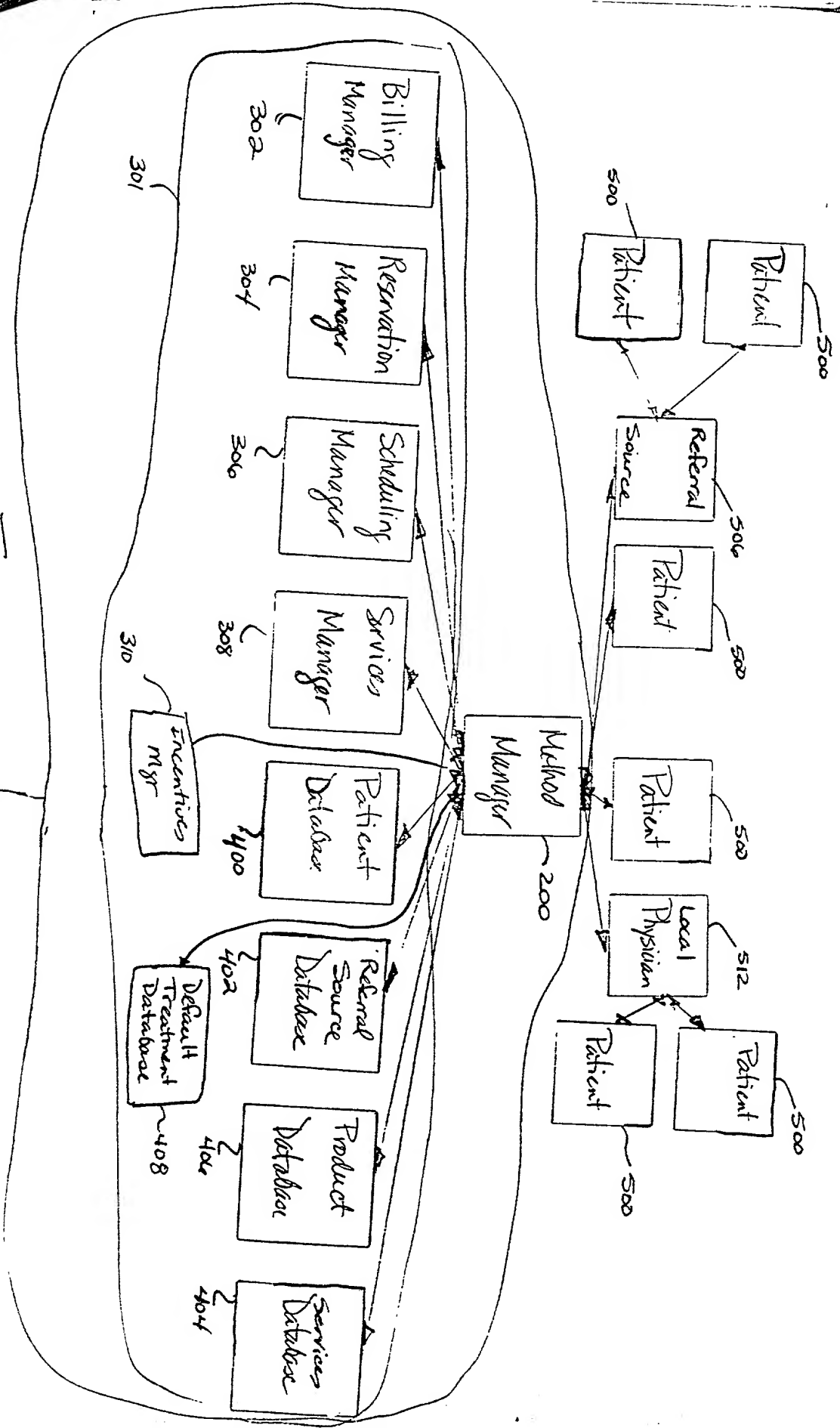




Fig. 3



10067087-020402

Care
Processor
301

Clock
604

Processor
602

Communication
Port
600

Program 608

Patient Database 400

Services Database 404

Product Database 406

Referral Source Database 402

606

301

FIG. 4

10067087.020402

204020-48043001

Patient Identifier 614	Patient Name 618	Patient Address 620	Geographical Location for Treatment and/or After Care 622	Medical Facility Identifier 624	Local Physician Identifier 626	Local Physical Contact Information 628	TPA/Insurance Company Identifier 630	Home Physical Identifier 632	Home Physician Contact Information 634	Expected Start Date Identifier 636	Expected Stop Date Identifier 640	Expected Length of Stay and Accommodation 642	Medical Procedure or Care Identifier 644

An Accommodation Preferences Identifier 646	Concierge Services Preferences 648	Personal Emergency Contact Information 650	Billing Status Identifier 652	Referral Source Identifier 654	Bundle Identifier 656	Reservation Identifier 616	Patient Birth Date 658	Patient Sex Identifier 638	Patient Allergies 739	Anniversary of the Procedure/Recovery 660	Default After Care Protocol and Notes 662	Prescribed After Care Protocol and Notes 664	Medical Record Information 666

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FIG. 5

204020-28049001

Referral Source Identifier 654	Referral Source Name 672	Referral Source Contact Information 674	Billing Type Information 676	Billing Status Information 652	Incentive Information 680	Client Patient Identifier Information 614	Medical Procedure or Care Identifier 644	Incentives Received Identifier 678	Incentives Due Identifier 682	Referral Information 683

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 Computer Program...
 Applicant: Sternlicht

FIG. 6

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Patient Identifier 614	Patient Name 618	Reservation Code 616	Bundle Identifier 656	Service Type Identifier 692	Service Provider Identifier 690	Time Identifier 694	Date Identifier 696	Cost Identifier 698	Billing Status Identifier 652

FIG. 7

2044220-28029001

204020-28043001

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Product Identifier 704	Product Price 706	Availability Identifier 708	Product Ingredients 710	Prescribed Uses for the Product 712	Medical Procedure or Treatment Identifier 644	Provider Identifier 714

Fig. 8

204020 45045001

Medical Procedure or Treatment Identifier 644	Medication Type Identifier 724	Medication Dosage Identifier 726	Treatment Type Identifier 728	Treatment Practice Identifier 730

FIG. 9

Docket No. H0649/7001
 Title: System, Method, and
 Computer Program...
 Applicant: Sternlicht

PRACTICE PROFILE

Prepared by	Date:
-------------	-------

Institution		
Location:		
Address:		
City	State	Zip

Referral Potential	Attitude			
	Q1	Q2	Q3	Q4
Pats				

Tel (Switch)	
Fax	
Website	

Key Personnel					
Contact	Title	First name	Initials	Last Name	Position Title

Types and Volumes of Patients	Services Required	Special Needs

Referral Process	Agreed Action (What)	Who?	When?

Marketing Process	Agreed Action (What)	Who?	When?

Training Process	Agreed Action (What)	Who?	When?

Relationship Building	Agreed Action (What)	Who?	When?

FIG. 10

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FIG. 11A

Docket No. H0649/7001
Title: System, Method, and
Computer Program...
Applicant: Sternlicht

TITLE: TUBE FEEDING MANAGEMENT PROTOCOL

PURPOSE: To outline the nursing management of patients receiving continuous, intermittent, or cyclic enteral tube feedings via nasogastric, gastrostomy, duodenostomy, or jejunostomy tube.

LEVEL OF PERSONNEL: RN LPN

PURPOSE: Tube feedings are employed to meet nutritional needs including hydration requirements when normal oral intake is altered or contraindicated. The potential for tube displacement puts these patients at risk for aspiration pneumonia, or peritonitis.

MD ORDER 1. Validate that tube feeding order states formula, volume, strength, rate, time span, and method of delivery (i.e. continuous, cyclic, bolus or gravity drip).

2. Measure, at time of feeding tube insertion, the length of visible tube and record on NPR.

ASSESSMENT 4. Assess for tube placement q 8 hours and before each intermittent feeding or medication administration, using at least two of the following measures:

- a. measure and compare length of visible tube to initial measurement
- b. aspirate gastric or small bowel contents (5-10ml, observe for appropriate color and consistency)
- c. instill 10 ml of air into tube while auscultating stomach (gastric only)

5. Assess gastrostomy/jejunostomy site q 24 hours for:

- a. leakage of formula around tube
- b. signs of infection (redness, induration, purulent drainage)

6. Assess patient's fluid balance q 24 hours:

- a. compare I/O, note fluid imbalances
- b. monitor weight changes
- c. monitor lab values (electrolytes, BUN, Cr.)

7. Assess general abdominal/digestive status q 8 shift:

- a. assess bowel sounds
- b. observe for signs/symptoms of feeding intolerance: repeated nausea/vomiting, cramping, diarrhea or gastric residual >100ml/1 hour.

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FIG. 11B

Docket No. H0649/7001
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Computer Program...
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REPORTABLE
CONDITIONS

8. Weigh patient q AM, unless otherwise ordered.
9. Maintain I&O q 8 hours.
10. Report promptly to MD:
 - a. suspected displacement of feeding tube
 - b. suspected aspiration, i.e. SOB, elevated temperature
 - c. obstruction of feeding tube
 - d. abdominal distention, nausea/vomiting, cramping, diarrhea, constipation
 - e. fluid-electrolyte imbalance
 - f. gastric residual >120 ml for 2 hours for adults,
0-3 month >30, 3-12 months >45, 14yr+ > 60,
if on bolus > 1/3 of previous feed.
 - g. suspected formula leakage around gastrostomy or
jejunostomy
 - h. temperature >101°F.
11. Administer all formulas at room temperature.
12. Elevate HOB 45 degrees during feeding and for 1 hour following
bolus or gravity feed.
13. Flush tube with 5ml for pedi, 10 ml for adult of warm water when
feeding is interrupted, stopped, or after each intermittent feeding.
14. Flush tube q 4 hours with 5ml of warm tap water if feeding is
continuous.
15. Stop gastric tube feeding if patient is placed flat or in Trendelenberg.
- 16.. Measure gastrostomy residual q 4 hours or before every intermittent
feeding:
 - a. if residual is > 100 ml, HOLD feeding for 1 hour.
 - b. Recheck residual, if still > than 100 ml, HOLD and notify
MD.
Reinstill aspirate.
17. Hold feeding for 1 hour if patient is nauseated, vomiting, or
abdominal distention is present, if symptoms do not improve, notify
MD.
18. Only hang a 4 hour supply of formula, do not leave open formula
containers at room temperature for more than 1 hour.
19. Change formula bag/tubing q 48 hours.

INFECTION

20100207 020402

FIG. 12A

TITLE: VENIPUNCTURE FOR BLOOD SAMPLING

LEVEL OF PERSONNEL: RN, LPN,

DESIGNATED CLINICAL AREA: All

PURPOSE: To obtain routine blood samples.

APPLICABLE POLICY STATEMENTS:

Individuals must successfully complete the training program to perform venipuncture for blood sampling.

A physician's order must be obtained for each test.

CRITICAL ELEMENTS:

1. Use of site in antecubital fossa is preferred if a vein is easily palpable. If a vein is not easily identified, sites in the lower arm or hand may be used, but only as a last resort.
2. Blood samples should not be drawn from an arm with a continuous IV infusion. For patients who should not have venipuncture performed in one arm, notify RN caring for patient, if applicable. IV infusion should be turned off in order to be able to draw blood.

EQUIPMENT:

Venoject (may substitute a #23 gauge butterfly needle and syringe)
Appropriate specimen tube with labels
Alcohol swabs
Gauze sponge
Tourniquet
Disposable gloves
Plastic bags for specimen transport
Appropriate lab requisitions

NURSING ACTIONS:

1. Identify the patient.
2. Position patient's arm.
3. Select site for venipuncture. (Figure 1)
4. Apply tourniquet proximal to chosen site.

SPECIAL CONSIDERATIONS:

4. Vein should be distinct-easily visible

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FIG. 12B

and/or palpable. Tourniquet should be tight enough to obstruct venous flow, but, not arterial flow (radial pulse should be palpable).

If vein is not prominent:

- a. Have patient open and close hand, making a fist, no more than 2 times.
 - b. Lightly tap vein site.
 - c. Take tourniquet off, then place extremity in a dependent position for a few minutes.
 - d. If necessary, apply moist heat for a few minutes.
 - e. Reapply tourniquet.
5. Cleanse site and surrounding area with alcohol. Repeat if skin is unusually soiled. Using second clean alcohol sponge, wipe the site once with a downward stroke.
 6. Put on gloves.
 7. Stabilize the extremity and using thumb, hold skin taut below prepped area just distal to intended puncture site.
 8. At a 15 degree angle, insert the needle, bevel up, through the skin parallel to vein.
- a. Opening and closing the fist more than 2 may increase lactic acid.
 - c. Promotes venous distention.
 - d. Use wash cloth moistened with warm tap water.
 5. Allow to air dry completely to prevent burning at site and prevent hemolysis. Alcohol mixing with blood causes hemolysis.
 8. Parallel approach decreases rolling of vessel.

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FIG. 12C

Docket No. H0649/7001
Title: System, Method, and
Computer Program...
Applicant: Sternlicht

NURSING ACTIONS:

9. Butterfly needle:

Withdraw desired amount of blood
and then release tourniquet.

Straight needle with vacutainer:

Remove tube immediately after filling
And insert next tube.

10a. Recommended order of filling multiple
tubes:

- 1) Blood Cultures
- 2) Red top-no anticoag
- 3) Blue top
- 4) Purple top
- 5) Gray top
- 6) Green top

10b. Invert the tubes gently about 10 times.

Withdraw desired amount of blood
(ie., last tube almost filled). Then
release tourniquet.

11. When using the vacutainer, remove tube
from needle holder to relieve vacuum
before removing needle from vein.

12. Place gauze sponge over puncture site,
remove needle and then apply pressure
over site until bleeding stops. Ask patient
to keep arm straight.

13. Check venipuncture site before leaving
room.

14. If butterfly needle and syringe is used,
place blood in appropriate specimen tubes
following above recommended guidelines.
Label tubes, place in bags and send to lab
with appropriate requisition.

SPECIAL CONSIDERTIONS:

9. Release of tourniquet prior to
removal of needle prevents extravasation
of blood into tissue or excessive bleeding
from puncture site.

Release of tourniquet just before blood
Drawing is complete allows for a last
"surge" of blood into specimen tubes.
However, if blood flow is sluggish, it is
best to leave tourniquet in place until the
desired amount of blood is obtained.

10a. The rule is to always collect blood in
the tube containing anticoagulant last.

10b. Blood needs to be mixed with the
additive in the tube for it to function
properly.

12. Bending the arm might cause a
hematoma.

13. If hematoma develops, apply warm
Moist soaks with wash cloth.

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FIG. 12D

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Computer Program...
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NURSING ACTIONS:

14. If butterfly needle and syringe is used,
place blood in appropriate specimen tubes
following above recommended guidelines.
Label tubes, place in bags and send to lab
with appropriate requisition.

SPECIAL CONSIDERATIONS:

REFERENCES:

Brunner and Suddarth (1988). Textbook of Medical-Surgical Nursing, (6th Edition). Philadelphia,
PA: J.B. Lippincott, p. 668.

College of American Pathologists (1996). So You're Going to Collect a Blood Specimen. An
Introduction to Phlebotomy. College of American Pathologists, Illinois.

Logston, Boggs, R., Woodridge-King, M. (1993). AACN Procedure Manual For Critical Care.
Philadelphia, PA: W. B. Saunders Company.

Milliam, Doris, A. (1987). Venous Blood Samples - Sharpen Your Drawing Skills. Nursing 87,
December, p. 56 - 61.

Nursing Procedures, second edition, (1996). Sprintghouse. Springhouse, PA

EXPERT RESOURCES:

Mary Liz Bilodeau, RNC, MS, CCRN
Critical Care CNS

Martha Martin, RN, MSN
Staff Specialist

Jill Pedro, RN, MSN, ONC
Clinical Nurse Specialist

PRACTICE AREA:

Department of Nursing

Department of Nursing

Department of Nursing

Approved: Council on Practice
Revised: Council on Practice /

FIG. 12E

Docket No. H0649/7001
Title: System, Method, and
Computer Program...
Applicant: Sternlicht

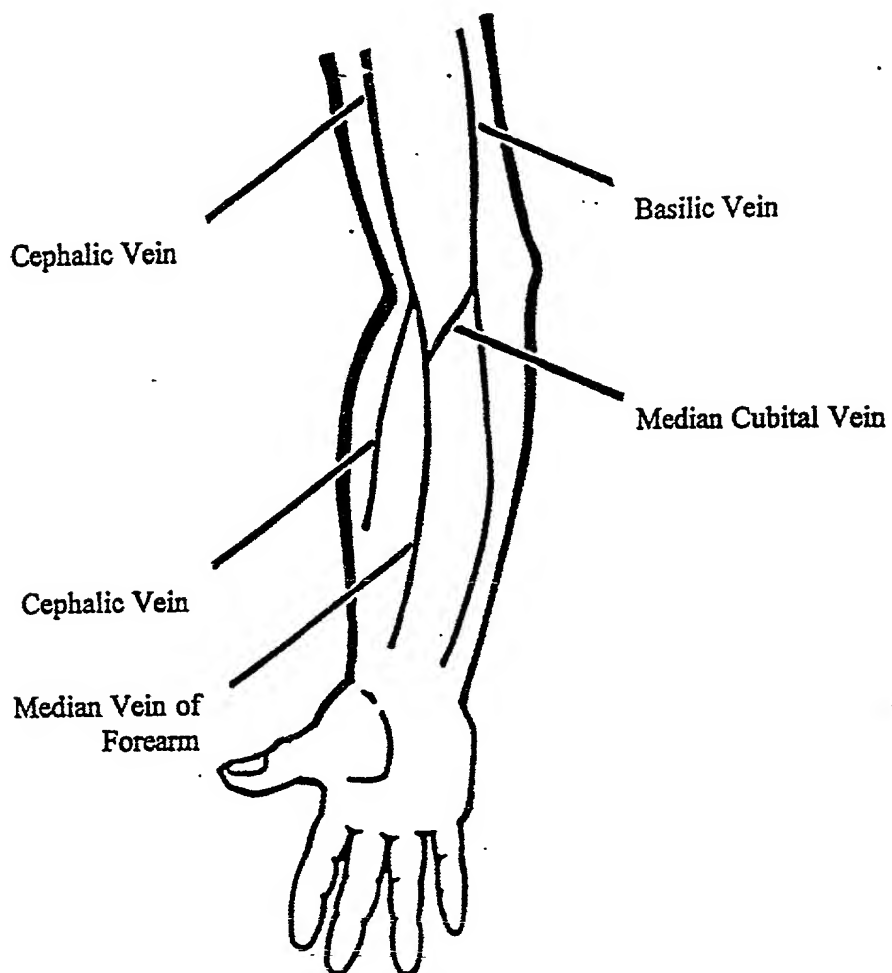


FIGURE 1 - Major Veins in Upper Extremity

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Applicant: Sternlicht

--	--

Name:

First	Initials	Last	Contact Telephone No.
-------	----------	------	-----------------------

Outward trip

From	month	day	yr	time	:	am/pm	Service Required:
------	-------	-----	----	------	---	-------	-------------------

Address

State	Zip code
-------	----------

To	Address	State	Zip code
----	---------	-------	----------

Return trip

From	month	day	yr	time	:	am/pm	Service Required:
------	-------	-----	----	------	---	-------	-------------------

Address

State	Zip code
-------	----------

To	Address	State	Zip code
----	---------	-------	----------

Notes on Required Nursing Services

--

Patient Information

Address:

--

City:

--

 State:

--

 Zip:

--

Phone - Home:

--

 Work:

--

 Cell:

--

email address:

--

 Fax:

--

Payment Guarantor Information

Name:

First	Initials	Last
-------	----------	------

Address:

--

City:

--

 State:

--

 Zip:

--

Phone - Home:

--

 Work:

--

 Cell:

--

email address:

--

 Fax:

--

Payment

Agreed fee for
above services
\$

Method

Cash	
Check	
Invoice Company	
Other	

Credit Card Type

Amex		Visa	
Card Number			
Issuer	Exp. Date		
Cardholder name shown on card			

Fig. 13

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--

To receive a free and confidential quotation without obligation, please give the following information:

Name: First	Initials	Last	Contact Telephone No:
-------------	----------	------	-----------------------

Arrival date:	nth	day	yr

Total number in party:

adults:

children:

How will you travel
to Boston?

Departure date:	nth	day	yr

Air
Rail
Car

Type of accommodation	
single room	
twin-bedded double	
family room	
junior suite	
parlor suite	

Total rooms required:

Approximate nightly budget per room (excluding meals)	
\$150 - \$200	
\$200 - \$250	
\$250 - \$300	
\$300 - \$400	
\$400+	

please state any particular requirements:
(special meals, adapted bathrooms, wheelchair access etc.)

Near to any particular hospital? (if so please indicate which)

Address:

City:

State:

Zip:

Phone - Home:

Work:

Cell:

email address:

Fax:

FIG. 14

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Title: System, Method, and
Computer Program...
Applicant: Sternlicht

PATIENT REFERRAL INFORMATION:

DATE: ____/____/____

REFERRED BY:

(name) _____

(Phone) _____

(Dept.) _____

(Email) _____

PATIENT NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____ CELL: _____

DOB: _____

DIAGNOSIS/PROCEDURE:

BRIEF MH/ALLERGIES:

ESTIMATED LENGTH OF STAY / TREATMENT: _____ days

REFERRING HOSPITAL _____

FLOOR _____ UNIT _____ ROOM NUMBER: _____

SURGEON: _____ PHONE: _____ FAX: _____

SERVICES TO BE PROVIDED: _____

DATES/HOURS OF SERVICES: _____

Please check here to confirm that Page One/Two has been faxed

FIG. 15

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Title: System, Method, and
Computer Program...
Applicant: Sternlicht

PATIENT REFERRAL INFORMATION:

DATE: ____/____/____ REFERRED BY: (Name)_____

(Phone)_____

(Dept.)_____

(Email)_____

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

PHONE: _____ FAX: _____ CELL: _____

DIAGNOSIS/PROCEDURE: _____

BRIEF PMH/ALLERGIES: _____

ESTIMATED LENGTH OF OUTPATIENT TREATMENT: _____ days/weeks/months

REFERRING HOSPITAL _____ FLOOR _____ ROOM NUMBER: _____

SURGEON/PHYSICIAN _____ PHONE: _____ FAX: _____

SERVICES
REQUESTED: _____

START DATES/HOURS OF SERVICES: _____

Please check here to confirm that Page One/Two has been faxed

PAYMENT INFORMATION:

Payment Guaranteed By:

Full Name: _____ (Relationship to Patient) _____

Address _____ Tel.No: _____

City _____ State _____ Zip _____ Email _____

METHOD OF PAYMENT: _____

CREDIT CARD DETAILS: _____

EXACT NAME ON CARD _____ EXPIRATION DATE _____

FIG. 16A

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Computer Program...
Applicant: Sternlicht

SUPPLIES:

Prescriptions to be filled/delivered _____ YES (Please attach scripts) _____ NO

Medical supplies needed: _____

Medical/Adaptive equipment needed: _____

CONCIERGE SERVICES:

HOTEL

- ☐ Hotel preferences or price range: _____
- ☐ Number of Rooms: _____
- ☐ Number of Occupants: _____
- ☐ Arrival date/time: _____ (please note: most hotels have a 1p check in policy)
- ☐ Anticipated Date of Departure: _____

Room Preferences

BEDSIZE: _____ SMOKING/NON: _____ STANDARD/SUITE: _____

OTHER: _____

TRANSPORTATION:

- ☐ Nurse escort via car/airplane
- ☐ Wheelchair accessible van
- ☐ Ambulance
- ☐ Limousine
 - ☐ Pick up date, time, location: _____

AESTHETIC SERVICES:

- ☐ Massage: _____
- ☐ Facial: _____
- ☐ Manicure: _____
- ☐ Pedicure: _____
- ☐ Makeup application: _____
- ☐ Hair Services (Cut/wash/perm/set): _____

SPECIAL REQUESTS:

FIG. 11bB

10067087-020402

FIG. 17

PHYSICIAN ORDERS

-

RN/Clinician's Signature_____

Physician Name _____ Address _____

City, State, Zip _____

Physician's Signature _____ Date _____

Reply: _____

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 Computer Program...
 Applicant: Sternlicht
MEDICATION RECORD

FIG. 18

ALLERGIES _____

Patient _____

	MEDICATION		DATE	DATE	DATE	DATE	DATE	DATE	DATE
START		A							
D/C		M							
RED		P							
START		M							
D/C		A							
RED		M							
START		P							
D/C		A							
RED		M							
START		P							
D/C		A							
RED		M							
START		P							
D/C		A							
RED		M							
START		P							
D/C		A							
RED		M							
START		P							
D/C		A							
RED		M							

INIT	SIGNATURE	INIT	SIGNATURE

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Computer Program...
Applicant: Sternlicht

FIG. 19A

PATIENT INTAKE FORM

PATIENT NAME: _____ DOB: _____

GUARDIAN NAME (IF CHILD): _____

PRIMARY PHYSICIAN: _____

DIAGNOSIS: _____

ALLERGIES: _____

CURRENT ADDRESS: _____

LOCAL PHONE#/ CELLULAR/ PAGER: _____

RELIGION: _____

COUNTRY OF ORIGIN: _____

PERMANENT MAILING ADDRESS: _____

PRIMARY LANGUAGE: _____

METHOD OF PAYMENT: _____

SOURCE OF REFERRAL: _____

NAME AND # OF PERSON CALLING IN CASE: _____

DATE OF ADMISSION: _____ DATE OF DISCHARGE: _____

START DATE OF SERVICES: _____

Docket No. H0649/7001

Title: System, Method, and
Computer Program...

DOCTORS ORDERS:

Applicant: Sternlicht

ANTICIPATED LENGTH OF TREATMENT:

ADDITIONAL THERAPIES:

☐ OCCUPATIONAL THERAPY:

☐ PHYSICAL THERAPY

☐ SPEECH THERAPY:

☐ RESPIRATORY THERAPY:

☐ INFUSION SERVICES:

☐ ESCORTING TO APPOINTMENTS:

☐ SCHEDULE FOLLOW UP APPT:

☐ TRANSPORTATION:

☐ LIVING ACCOMODATIONS:

☐ OTHER:

DATE/TIME/SIGNATURE OF INTAKE WORKER:

PRIMARY NURSE ASSIGNED TO CASE:

FIG. 19B

Docket No. H0649/7001
Title: System, Method, and
Computer Program...
Applicant: Sternlicht

FIG. 20

CONCIERGE:

☐ HOTEL: _____ ARRIVAL: _____ DEPARTURE: _____

ROOM PREFERENCES:

BEDSIZE: _____ SMOKING: _____ STANDARD/SUITE: _____

OTHER PREFERENCES: _____

☐ TRANSPORTATION:

PICKUP DATE/TIME/LOCATION: _____

☐ MEALS: _____

☐ AESTHETIC SERVICES:

☐ MASAGE: _____

☐ FACIALS: _____

☐ MAINCURE: _____

☐ PEDICURE: _____

☐ MAKEUP APPLICATION: _____

☐ OTHER: _____

COMMENTS: _____

FOR OFFICE USE ONLY: (PLEASE INITIAL WHEN COMPLETED)

- ☐ STAFF ASSIGNED: _____
- ☐ HOTEL BOOKED: _____
- ☐ TRANSPORTATION CONFIRMED _____
- ☐ PATIENT NOTIFIED OF ALL DETAILS IN WRITING: _____
- ☐ CONTACT MADE WITH SURGICAL TEAM: _____
- ☐ PATIENT INVOICED: _____
- ☐ FOLLOW UP LETTER SENT TO PATIENT: _____
- ☐ FOLLOW UP LETTER SENT TO PHYSICIAN: _____

10067087.020400

FIG. 21

Patient _____

[illegible]

INIT	SIGNATURE	INIT	SIGNATURE

THE

Applicant: Sternlicht
INTAKE & OUTPUT

Patient Name _____ DOB _____

INTAKE					
DATE TIME	ORAL AMT/Subtotal	IV AMT/Subtotal	PGT AMT/Subtotal		
DAILY TOTAL					
DAILY TOTAL					
DAILY TOTAL					
DAILY TOTAL					
DAILY TOTAL					
DAILY TOTAL					
DAILY TOTAL					

OUTPUT						
DATE TIME	URINE AMT/Subtotal		STOOL AMT/Subtotal		VOMIT AMT/Subtotal	
DAILY TOTAL						
DAILY TOTAL						
DAILY TOTAL						
DAILY TOTAL						
DAILY TOTAL						
DAILY TOTAL						
DAILY TOTAL						

204020-28049007

Fig. 23

PATIENT TIME SHEET: NURSING

Month

Patient Name

Location

Patient Signature

Staff Signature

Date of Mo	SHIFT 1			SHIFT 2			SHIFT 3			Total Hours
	Nurse Name	Time In	Time Out	Nurse Name	Time In	Time Out	Nurse Name	Time In	Time Out	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
Totals										

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Computer Program
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Title: System, Method, and
Computer Program...
Applicant: Sternlicht

FIG. 24A

**PHYSICAL THERAPY
Initial Evaluation**

Date:

Name	Physician
Parent	Case Manager
Address	Primary PT
Date of Birth	Chief complaint
Gestational age	
Diagnosis	

SUBJECTIVE

PMH:

Social hx

Prior level of functioning:

Precautions:

Hx of present illness:

Pain

Medications

MUSCULOSKELETAL ASSESSMENT

Title: System, Method, and
Computer Program...

Applicant: Sternlicht

Joint range of Motion ☐ WNL

Motion	Position	Mon		Arom	
		Right	Left	Right	Left

Muscle Strength ☐ WNL

Muscle	Position	Grade	
		Right	Left

Muscle Tone

Sensory

REFLEX PROFILE

Supine

Prone

Sitting

Quadruped

Standing/vertical Suspension

Horizontal Suspension

GROSS MOTOR EVALUATION

Title: System, Method, and
Computer Program...

Applicant: Sternlicht

Prone

Supine

Sitting

Quadruped

Kneeling

Half Kneeling

Standing

Ambulation

Stair Climbing

Ball Skills

Balance

Static

Dynamic

Standing

Sitting

FIG. 24C

FINE MOTOR ASSESSMENT

Docket No. H0649/7001

Title: System, Method, and

Computer Program...

Applicant: Sternlicht

Focus/Visual Tracking

Approach

Grasp

Manipulation

Release

Transferring

Bilateral Activities

ACTIVITIES OF DAILY LIVING

Feeding

Dressing

Hygiene

204020-38049001

EQUIPMENT

Docket No. H0649/7001
Title: System, Method, and
Computer Program...
Applicant: Sternlicht

SUMMARY

Assessment:

Problems:

Plan of Care:

Goals:

Expected Visits

Signature _____

PT

Date _____

FIG. 24E

204020-289288

PATIENT TIME SHEET: THERAPY VISITS

Month

Patient Name
Location

Patient Signature
Staff Signature

Date of Mo	SHIFT 1			SHIFT 2			SHIFT 3					
	Therapist Name	Time In	Time Out	Total Hours	Therapist Name	Time In	Time Out	Total Hours	Therapist Name	Time In	Time Out	Total Hours
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
Totals												

Docket No. H0649/7001
Title: System, Method, and
Computer Program...
Applicant: Sternlicht

Docket No. H0649/7001
Title: System, Method, and
Computer Program...
Applicant: Sternlicht

FIG. 26

PHYSICIAN MEMORANDUM

Date: _____

Physician: _____ Office/Fax: _____

Patient: _____ DOB: _____

☐ Patient Status Update

☐ Additional Service Request

☐ Orders

☐ Other

Comments:

R.N./Clinicians Name _____ Contact Number: _____

Reply:

Physician's Signature: _____ Date: _____

FIG. 27

NAME		TEACHING / PARENTS	
AGE			
ALLERGIES		APPOINTMENTS	
HISTORY			
DEVELOPMENT		ELIMINATION	
NUTRITION		RESP	
Central	U/O	Vomit	Stool
PGT			Other
PO			
Weight			
Mouthcare			
SKIN / DSGS			

Docket No. H0649/7001
Title: System, Method, and
Computer Program...
Applicant: Sternlicht

FIG. 28A

TO BE COMPLETED BY THE PATIENT, FAMILY MEMBER OR NURSE			FOR NURSE USE ONLY																					
<p>1. What language do you speak? _____</p> <p>2. Why do you need home care services? _____</p> <p>3. Do you have ALLERGIES to medicines/ latex/ food? If yes, list _____</p> <p>4. What is the hospital you are being treated at? _____</p> <p>5. Who is your primary doctor? _____</p> <p>6. Are there other doctor's involved in your care? _____</p> <p>7. Do you smoke? <input type="checkbox"/> no <input type="checkbox"/> yes How much? _____</p> <p>8. Do you use recreational drugs? <input type="checkbox"/> no <input type="checkbox"/> yes How much? _____</p> <p>9. Do you use alcohol? <input type="checkbox"/> no <input type="checkbox"/> yes How much? _____</p> <p>10. Please list all medications you are presently taking below</p> <table border="1"><thead><tr><th>Medication</th><th>Dose</th><th>Purpose</th></tr></thead><tbody><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr></tbody></table>			Medication	Dose	Purpose																			<p>HEALTH PERCEPTION MANAGEMENT</p> <p><input type="checkbox"/> Needs health teaching</p> <p><input type="checkbox"/> Needs med teaching</p>
Medication	Dose	Purpose																						
<p>11. Do you have enough information about your medications? <input type="checkbox"/> no <input type="checkbox"/> yes</p>			<p>ELIMINATION</p> <p><input type="checkbox"/> Needs output regimen</p>																					
<p>12. Do you have any problems with your bowels? <input type="checkbox"/> no <input type="checkbox"/> yes Please describe _____</p> <p>13. Do you have any problems with urinating? _____</p>																								
<p>14. Do you have any problems with your intake of food? (eating, swallowing, chewing, nausea/vomiting)? <input type="checkbox"/> no <input type="checkbox"/> yes Please describe _____</p> <p>15. Do you follow any special diets? <input type="checkbox"/> no <input type="checkbox"/> yes Please describe _____</p> <p>16. Does you have any skin problems? (rashes, bruises, reactions, cut, bumps)? <input type="checkbox"/> no <input type="checkbox"/> yes Please describe _____</p>			<p>NUTRITION/ METABOLIC</p> <p><input type="checkbox"/> Needs nutrition teaching</p> <p><input type="checkbox"/> Needs nutrition material</p>																					
<p>17. Are there any limitations to your activities? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____</p> <p>18. Do you need assistance with any daily activities? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____</p> <p>19. Do you have or need any special equipment? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____</p>			<p>ACTIVITY/EVERCISE</p> <p><input type="checkbox"/> PT needed</p> <p><input type="checkbox"/> OT needed</p>																					

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20. Do you have any problems sleeping? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____	SLEEP/REST
21. Do you have enough energy for your daily activities? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____	
22. Do you have any problems with <input type="checkbox"/> memory <input type="checkbox"/> vision <input type="checkbox"/> hearing? Describe _____	COGNITIVE/ PERCEPTUAL
23. Do you any questions or concerns about your sexuality/reproductive system? <input type="checkbox"/> no <input type="checkbox"/> yes List _____	SEXUALITY/ REPRODUCTIVE
24. How are you coping with your health issues at the present time? _____	COPING/STRESS
25. Has your illness changed your life significantly? <input type="checkbox"/> no <input type="checkbox"/> yes Deacribe _____	SELF PERCEPTION
26. Who are the important people to be involved in your care? _____	ROLE/RELATIONSHIP
27. Who shall we contact in the event of any emergency? _____ Telephone _____	
28. Do you have a health care proxy? <input type="checkbox"/> no <input type="checkbox"/> yes name _____	
29. Are there any religious practices that we can support? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____	VALUE/BELIEF
30. Are there any needs medically and personally that we can assist you with? <input type="checkbox"/> no <input type="checkbox"/> yes List _____	
NURSING ISSUES TO BE ADDRESSED	
Information obtained from _____ Nursing Signature _____ Date _____	

Progress Note

FIG. 29

Age:

Allergies:

Physician:

[illegible]